Nos. 81-746 and 81-1172

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Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.,

Cross-Petitioners,

—v.—

CITY OF AKRON,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

RESPONDENTS AND CROSS-PETITIONERS' BRIEF

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QUESTIONS PRESENTED

Questions presented for review to this Court by Petitioner, Defendant City of Akron appear in Defendant's Brief, p. i.

Questions presented for review to this Court by Cross-Petitioner, Plaintiffs are:

1. Whether this Court's summary affirmance of *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894 (N.D.Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934, (1981), compelled the United States Court of Appeals for the Sixth Circuit to uphold an ordinance of the City of Akron, Ohio mandating that all abortions after the first trimester of pregnancy be performed in hospitals accredited by the Joint Commission on Accreditation of Hospitals.

2. Whether the requirement that all second trimester abortions be performed in hospitals, regardless of the techniques used or the stage of gestation, is unconstitutional because it unnecessarily burdens women needing such abortions and their physicians and is not narrowly drawn to further legitimate maternal health interests.

PARTIES

Petitioner, the City of Akron, was Defendant below with John Ballard, Mayor; Dr. C. William Keck, Director of Public Health; and Peter Oldham, Prosecutor. Defendant-intervenors in the trial court were Dr. Francois Seguin and Mrs. Kathleen Black who were permitted to intervene solely in their capacity as parents of unmarried minor daughters of child bearing age. Plaintiffs below, Akron Center for Reproductive Health, Inc.; Akron Women's Clinic, Inc.; WomenCare, Inc.; and Dr. Robert Bliss, a physician representing himself and the rights of adult and minor patients needing abortions in Akron, are Respondents and Cross-petitioners in this litigation.

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OPINIONS BELOW

(See brief of Defendant, City of Akron)

JURISDICTION

The Judgment of the United States Court of Appeals for the Sixth Circuit was entered on June 12, 1981. The court of appeals denied all parties' petitions for rehearing by July 22, 1981. Defendant-Intervenors' petition for writ of certiorari was denied on May 24, 1982. Defendants' petition for writ of certiorari was filed on October 13, 1981 and granted on May 24, 1982. Plaintiffs' cross-petition for writ of certiorari was filed December 19, 1981 pursuant to Associate Justice O'Connor's order of October 16, 1981, extending the time for filing. Plaintiffs' cross-petition for writ of certiorari was granted on May 24, 1982. This Court's jurisdiction is invoked under Title 28, U.S.C. Section 1254 (1).

CONSTITUTIONAL AND STATUTORY PROVISIONS

1. *United States Constitution*, Article III, Sections 1,2.
   United States Constitution, Amendment I
   United States Constitution Amendment XIV, Section 1.
2. *Ohio Constitution Article XVIII, Section 3.*
   (For text of above, See Appendix F to this brief)
3. *The City of Akron Ordinance, Number 160-1978*
   Reprinted in the appendix to Defendants' petition for writ of certiorari. (Pet. A pp. 115a-129a)

4. The pertinent parts of the Ohio Revised Code Chapters 2151, 3109, 2317, 2919 and the Ohio Revised Administrative Code: Chapter 3701-47 are reprinted in the Joint Appendix at pp. 325a-339a and p. 299a.

STATEMENT OF THE CASE

A. History of the Legislation

Clinics and physicians in the City of Akron, Ohio, provide needed abortion services for women from all over northeast Ohio, and from as far away as Columbus, Ohio, and West Virginia. (Goldberger, T. VI, 116.)[1] In 1977, the year before this ordinance was enacted, more than 95% of all abortions in Akron were performed by the three plaintiff clinics.[2] No one disputed that the clinics had an excellent health care record and, as Defendant Dr. C. William Keck, Director of Health of the City of Akron, stated, the rate of major complications "could hardly be lower." (P.Ex. 48, J.A. 309a.)

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[1] The following designations are used to refer to the documents filed with this Court in this litigation: "J.A."—Joint Appendix; "T."—Transcript of the district court proceedings (with the volume number preceding the page number, i.e., V, 116); "R."—Record item (numbered according to the list of items transmitted to this Court); "Ex./T." refers to the transcript pages at which the exhibit was offered and admitted into evidence (these references appear in the J.A. for those exhibits contained within it), pursuant to Supreme Court Rule 34 (.5). The lower court opinions in this case are reproduced in the appendix to the Petition for Certiorari ("Pet.A."). Since the most recent United States government statistics available at the trial of this case in 1978 were from 1975 (Crist, T.I, 34), plaintiffs also refer to the certified record of a related case before this Court, *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft*, U.S. S.Ct., Nos. 81-1255, 81-1625; "Ash.A."—Joint Appendix of *Planned Parenthood Association of Kansas City, Missouri v. Ashcroft*. For the Court's convenience, frequently referred to exhibits from *Ashcroft*, as well as recent medical and statistical publications, are reproduced in a volume lodged with this brief. ("L.doc."). L.doc. 1/Ash. D.Ex. 1 (on remand) refers to an exhibit submitted in the *Ashcroft* trial on remand and in the certified record before this Court. A list of witnesses and their credentials is provided in Appendix A to this brief.

[2] The three plaintiff clinics, Akron Center for Reproductive Health, WomenCare, and Akron Women's Clinic performed approximately 5,280 of the 5,574 reported abortions performed in Akron in 1977 (P.Ex. 48, J.A. 309a; Gottshall, T.II, 8-9; Goldberger, T.II, 148; Hurst, T.III, 26.)

The clinics' excellent health care record was verified through an ongoing audit and review by the medical community of Summit County, Ohio, in which the City of Akron is located. From the time the clinics opened in late 1976 to the time the present litigation began in April 1978, the clinics were inspected and approved by eight different officials and organizations, including Defendants Dr. Keck, Dr. Ernest Estep, medical director of the Planned Parenthood Association of Summit County, and Dr. Charles V. Bowen, ranking obstetrician-gynecologist of the Summit County Medical Society.[3] (P.Ex. 50, J.A. 317a; P.Ex. 48, J.A. 304a; P.Ex. 51, J.A. 320a; Parker, J.A. 169a; Crossman, J.A. 218a.) Further, the clinics met the rigorous medical referral standards of Planned Parenthood Federation of America, the Summit County Medical Society, and various public welfare agencies. (P.Ex. 50, J.A. 317a-318a; P.Ex. 51, J.A. 320a; Crossman, J.A. 218a.)

Prior to the enactment of this criminal statute, first trimester abortions were regulated in Akron in the same manner as all other medical services.[4] (P.Ex. 48, J.A. 306a.) The Akron Health Department had, according to its director, "full authority to deal with all matters concerning the public health and sanitation." (*Id.* at J.A. 306a.) In addition, the medical community established a voluntary audit and review committee focused exclusively on the clinics. It inspected them, offered recommendations, and did "follow-up inspections." (P.Ex. 50, J.A. 317a.)

In October 1977, a bill was introduced in the Akron City Council to regulate abortion in the City of Akron. (P.Ex. 42/T.II, 246, 247; Segedy, T.II, 219.) The drafters and sponsors

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[3] Dr. Bowen visited each clinic at least twice. (P.Ex. 50, J.A. 317a.) Separate inspections were conducted by the Stark County Planned Parenthood Association, the Summit County Welfare Department, and the Ohio Welfare Department. (Parker, J.A. 169a; Crossman, J.A. 218a.)

[4] Defendant Dr. Keck, stated that there were "268 physicians and dentist sub-specialists practicing in Akron who may perform one or more of many surgical procedures in their offices with risk comparable to abortion. . ." (P.Ex. 48, J.A. 310a.)

neither visited the clinics nor examined medical statistics concerning abortion care in Akron and were wholly unfamiliar with the informed consent and counseling practices of the Akron clinics. (Segedy, J.A. 145a-146a; Kapper, J.A. 204a-205a.) The drafters' intent, according to one of their number, was to prepare and enact a "national model" anti-abortion ordinance. (Weinberger, R. 171, p. 39/J.A. 322a.)[5]

Between October 1977 and February 1978, the Akron City Council considered the proposed legislation. A series of drastic departures from normal legislative procedure punctuated the deliberations. Selected councilmen held a secret meeting to hear testimony in favor of the ordinance; the public and council members opposed to the ordinance were excluded from this meeting. (Weinberger, R. 171, pp. 98-99/J.A. 323a.) Chapter 1870 was one of only two ordinances considered by the Council over at least a three year span not drafted by the city law department (Brooks, J.A. 173a), and the only bill enacted in that period contrary to the advice of the city law department's representative to the Council that the bill was, in large measure, unconstitutional. (Brooks, J.A. 176a.) It was the only ordinance in recent memory which was redrafted in City Council committee sessions attended by outsiders, i.e., the original drafters of the "model anti-abortion" ordinance. (Brooks, J.A. 172a; Segedy, J.A. 146a.) Finally, Chapter 1870 was enacted without distributing copies of the final text to council members prior to the final vote. One member of the council admitted this was "very unusual." (Brooks, J.A. 177a.)

Chapter 1870 was adopted despite evidence showing no medical or health-related need for it. Defendant Dr. Keck, Akron Director of Health, stated:

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[5] Because it was drafted as a "model," Chapter 1870 contains several provisions inapplicable to Akron, including § 1870.13, which bans abortions in "municipal hospitals." As the chief councilman-sponsor of the bill testified, Akron has never had a municipal hospital or similar facility and has no plans to build one. (Kapper, J.A. 205a.)

> From the point of view of protecting the health of women involved, there is no compelling reason to regulate Akron's abortion facilities. If data exists of sufficient quality to contradict that which is available to me, I'd be pleased to evaluate it. (P.Ex. 48, J.A. 309a.)[6]

The ordinance passed by a vote of seven to six and became law without the signature of the Mayor of the City of Akron, Defendant John Ballard, who stated:

> I don't believe any credible evidence has been advanced to suggest that adequate and proper medical standards and procedures are being ignored in Akron. Therefore, I don't believe it has been demonstrated, from a medical standpoint, that further regulation is necessary. Further, it appears to me that the thrust of this ordinance may run counter to now well-established case law, in that it possibly invades constitutionally guaranteed rights of women who desire to have an abortion. (P.Ex. 51, J.A. 320a.)

However, he declined to veto the bill, stating: "I don't feel I should presume to decide these questions [the legality and constitutionality of the ordinance]—the courts are the proper place for the resolution of questions of law." (*Id.*)

B. The History of the Litigation

Plaintiffs rely on the procedural overview presented in defendants' brief, except for three corrections. First, defendants never appealed the district court's invalidation of Section 1870.05(B), requiring parental consent. Only the defendant-intervenors appealed this section to the Sixth Circuit Court of Appeals. (See Sec. III, p. 45, *infra.*) Second, defendants concede the unconstitutionality of subsections (3), (4), and (5) of Section 1870.06(B). (D.Brief, p. 37; D.Brief to the Sixth Circuit Court of Appeals, at 9-10, 35-36.) Third, defendants

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[6] Dr. Charles Bowen, speaking on behalf of the Summit County Medical Society, also concluded that, "there is no medical need for an ordinance to be introduced." (P.Ex. 50, J.A. 317a.)

mischaracterize the questions on which plaintiffs' cross-petition for certiorari was granted. (D.Brief, p. 3.) The correct Questions Presented appear at page (i).

In addition, plaintiffs note that the district court denied the separate motions of a pregnant woman and of a doctor who worked at one of plaintiff clinics, to proceed as plaintiffs under pseudonyms, and that these orders were affirmed by the Sixth Circuit Court of Appeals. (R. 15, 23, 26, J.A. 53a, 57a; Pet.A. 22a.)

C. Facts

1. Introduction.

The legalization of abortion has produced dramatic improvements in the health of American women and children. Since having become a legal medical procedure, abortions are being performed safely, at reduced costs, and with constant improvement in techniques and procedures. Today, abortion is both the most frequent form of minor surgery, and also one of the safest.[7]

From 1972 to 1978, abortion-related deaths (legal and illegal) fell by 70%, with a similar decline in complications. (L.doc. 1, p. 3, 4/Ash. D.Ex. 1 (on remand).)[8] Mortality rates

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[7] Comparative data from one of the plaintiffs' expert witnesses, Dr. Crist, established that the mortality rate for a first trimester abortion is about 1.2 per 100,000 procedures (T.I, 120), with a mortality rate of only .5 per 100,000 for those abortions performed under 8 weeks gestation. (Tietze, T.IV, 156.) In comparison, the mortality rate for childbirth ranges from 10 to 71.4 per 100,000, depending on age (T.I, 35), and for simple tooth extraction, 174 per 100,000 procedures. A penicillin shot carries a risk of 1.4 to 2 deaths per 100,000 patients. (Crist, J.A. 90a.) The risk of having to undergo major surgery for an abortion complication is approximately one one-hundredth that of having to undergo major surgery for a complication resulting from carrying a pregnancy to term. (L.doc. 1, p. 5/Ash. D.Ex. 1 (on remand).)

[8] United States government epidemiologists have recently determined that one-third or more of the women who died from legal abortion between 1972 and 1978 had medical conditions considered so potentially life-threatening that a therapeutic abortion would have been justified. (L.doc. 4, p. 190.)

have declined primarily because legal abortion is safer than any other alternative available to pregnant women. Expert testimony at the trial established that first trimester abortions are from 8 to 35 times safer than childbirth. (Crist, J.A. 90a.)[9] Furthermore, health risks of pregnancy and childbirth are greatly exacerbated when a pregnancy is unwanted. (L.doc. 1, p. 4/Ash. D.Ex. 1 (on remand).)

Delay is the most serious factor increasing the risk of an abortion. For every one week of delay, the risk of mortality increases about 50% and the risk of morbidity (serious complications), about 20%. (Tietze, T.IV, 156.) One major reason for the increased safety of abortion over the past ten years is that women are getting abortions at progressively earlier gestational ages.[10]

Despite the critical medical importance of prompt access to abortion services, most women in the United States cannot obtain abortions from their ordinary source of medical care. In 1980, only 10% of all obstetrician-gynecologists in private practice reported performing abortions in their offices; only 17% of all the public hospitals in the United States and 34% of the private hospitals reported doing at least one abortion.[11]

These national statistics reflect the situation in Akron, Ohio. There are no public hospitals, three of the five private hospitals

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9 Two government studies recently published in the *Journal of the American Medical Association* (See L.docs. 4 & 5) further support this conclusion, finding that the risk comparisons between abortion and childbirth underestimate the relative safety of abortion for pregnant women. For all ages, childbearing has a higher risk of death than abortion. And, while the risks of pregnancy vary with age, abortion risks remain lower and essentially constant across age groups (Crist, T.I, 35; Heald, T.II, 71-72).

10 In 1978, 52% of all abortions were performed in the first eight weeks of pregnancy, when the mortality rate is only .05 per 100,000 abortions. (L.doc. 2, p. 4/Ash.A. 88.)

11 Henshaw, *Abortion Services in the U.S. 1979-1980*, 14 Fam. Plan. Persp. 6, 11, 12 (1982) (L.doc. 7). Furthermore, only 22% of all abortions take place in hospitals, and only 32% of the hospitals that provide abortions will do any abortions after 14 weeks of pregnancy. (*Id.* at 15.)

do no abortions, and the other two hospitals report very few. (Stipulation, J.A. 197a; P.Ex. 47, J.A. 301a-303a; P.Ex. 46, J.A. 300a.) At the time of trial in 1978, second trimester abortions were not available in hospitals in Akron. (Gotshall, J.A. 113a.)

Because abortions are rarely available in hospitals, ambulatory facilities have developed to meet this special need.[12] In 1973, over 60% of all abortions were performed in hospitals. In contrast, by 1979, over 70% of all abortions were performed in free-standing clinics. (L.doc. 1, p. 8/Ash. D.Ex. 1 (on remand).)[13] This trend benefits women needing abortions, since the quality of care provided in specialized clinics is generally very high, and the average cost of an abortion in a clinic is much less than the cost of an abortion in a hospital. (L.doc. 1, p. 8/Ash. D.Ex. 1 (on remand).)

In spite of this beneficial trend, the unavailability of abortion providers is a continuing problem.[14] This problem will only be exacerbated by statutes, such as Chapter 1870, which use criminal sanctions to discourage doctors from performing abortions and to harass women seeking abortions. Doctors who wish to practice conscientiously and avoid the risks of criminal prosecution will simply decline to do abortions.

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12 Abortion is only one type of surgery done increasingly on an ambulatory basis in clinics. See Foster, *Ambulatory Gynecologic Surgery*, in Ambulatory Care in Obstetrics and Gynecology 399 (G. Ryan 1980).

13 In 1980, 76% of all abortions were performed in clinics and hospitals serving 1,000 or more abortion patients per year. (L.doc. 7, p. 10.)

14 The Alan Guttmacher Institute estimated that, nationwide, 29% of the women in need of abortion services were unable to obtain them in 1979. (L.doc. 6.) These women have been unable to obtain abortion services, in part, because of the continued inaccessibility of abortion facilities; 78% of U.S. counties and 59 Standard Metropolitan Statistical Areas had no facilities in which legal abortions were performed in 1980. (L.doc. 7, pp. 5, 10.)

2. The Requirement That All Second Trimester Abortions Be Performed in Hospitals Endangers Health Because Hospitals Are Unavailable and Early Second Trimester Abortions Are Safely Performed in Outpatient Clinics.

Section 1870.03 requires that every abortion performed subsequent to the end of the first trimester be performed in a hospital.[15] The evidence demonstrated that this requirement serves no health interests because early second trimester abortions performed in clinics are as safe as, or safer than, those performed in hospital facilities; that Akron hospitals are not available to meet the need for second trimester abortions; and that the hospital requirement imposes severe burdens on women by making second trimester abortions more expensive, more time-consuming, and less geographically accessible. The Sixth Circuit Court of Appeals found decisions invalidating identical provisions on the basis of such proof, "persuasive." (Pet.A. 21a.)

In 1972, the accepted medical practice was to perform abortions after the first trimester by the use of instillation techniques.[16] Recent research and practical experience throughout the United States have demonstrated that a medical technique called dilatation and evacuation ("D&E")[17] is now the preferred technique for second trimester abortions, particu-

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15 As defined by § 1870.01(B), this means "a general hospital or special hospital devoted to gynecology or obstetrics which is accredited by the Joint Commission on Accreditation of Hospitals, or by the American Osteopathic Association."

16 The two main instillation techniques are saline amniocentesis and prostaglandin amino infusion. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75 (1976). In 1973, saline instillation procedures accounted for 80% of all second trimester abortions. (Ash.A. 46.)

17 D&E is an extension of the first trimester dilatation and curettage procedure. It typically involves use of small forceps for the removal of fetal material, a suction cannula for the aspiration of amniotic fluid and placental and fetal debris, and a surgical curette to ensure complete evacuation. (Crist, T.I, 30.)

larly those up to 18 weeks of pregnancy. Development of the D&E procedure has significantly increased the safety, convenience, and speed of second trimester abortions and has also reduced costs.

Second trimester abortions by D&E are more than twice as safe as those performed by the instillation method (Crist, J.A. 91a),[18] and much safer than childbirth. (L.doc. 3, pp. 402, 404/Ash.A. 81, 83.) By 1978, D&E abortions accounted for 51% of all second trimester procedures. (L.doc. 3, p. 401/Ash.A. 79.) In the 13th to 15th weeks of pregnancy, the former "gray zone,"[19] 82% of all abortions were performed by the D&E method. (L.doc. 2, p. 4/Ash.A. 90.)

Both statistical evidence and expert testimony at trial demonstrated that early second trimester D&E abortions may not only be safely performed in qualified non-hospital facilities, but, in some circumstances, may actually be safer in clinics. (Crist, J.A. 93a; Kerenyi, J.A. 212a; L.doc. 3, p. 406/Ash.A. 85.)[20] By 1980, the vast majority of second trimester D&E

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18 The latest government statistics from the U.S. Center for Disease Control show that mortality risks from saline abortions are well above the risks of the D&E procedure. (L.doc. 2, p. 49/Ash.A. 94.) Government statistics concerning morbidity presented at the trial of this case in 1978 showed that early second trimester abortions done by the D&E method were more than 160% safer than instillation procedures. (P.Ex. 48, J.A. 315a.)

19 The D&E method does away with the "gray zone," the period between 13-15 weeks gestation, when it is too late for a first trimester vacuum suction procedure, but too early for instillation procedures. Thus, women in their thirteenth week of pregnancy are no longer forced to incur significant health risks by postponing an abortion for three or more weeks until an instillation procedure can be performed. (Crist, J.A. 89a, 92a.)

20 Plaintiffs' expert, Dr. Crist, testified that performing a D&E in a free-standing clinic maximizes safety for the patient because most physicians in free-standing clinics have extensive experience in performing D&E's. In a hospital setting, patients are more likely to be treated by inexperienced physicians in training. (Crist, J.A. 93a; Ash.A. 48, 58-59.) In addition to the safety of clinic abortions, clinics generally are more sensitive to the woman's mental health needs. (Hofmann, J.A. 167a.) Clinic personnel, unlike hospital staff, are selected and trained to serve abortion patients, and the clinics

procedures were performed in non-hospital facilities. (Ash.A. 46.)[21]

The standards of major medical organizations reflect the fact that early second trimester abortions are safe and desirable clinic procedures. In 1981, the American College of Obstetricians and Gynecologists (ACOG) endorsed the provision of early second trimester abortions in outpatient clinics, stating:

> Generally, abortions in the physician's office or outpatient clinic should be limited to 14 weeks from the first day of the last menstrual period. In a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility, abortions should be limited to 18 weeks from the last menstrual period. (See 1982 ACOG manual of standards, p. 16, Appendix B to this brief.)

The College's now obsolete policy recommending that second trimester abortions be performed only in hospitals, was the only proof offered by the defendants to support the in-hospital requirement. (Schmidt, T.X, 29; Pet.A. 19a.)[22]

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provide trained abortion counselors. Dr. Hofmann testified that the very best of counseling and support systems are available in the free-standing abortion clinics, while hospital personnel are often insensitive, particularly to adolescent needs. (J.A. 167a; American Public Health Association Resolution, Nov. 1979, Appendix C to this brief at 7a.)

21 This figure would be much higher, but for the fact that sixteen states have laws in effect which limit second trimester abortions to hospitals. Such laws have been enjoined in six additional states. (See Appendix E to this brief.)

22 In 1979, the American Public Health Association also endorsed second trimester abortions in qualified clinics. See *APHA Recommended Program Guide for Abortion Services* (revised 1979, 70 Am. J. Pub. Health 652, 654 (1980)), Appendix C to this brief. Similarly in 1980, the National Medical Committee of the Planned Parenthood Federation of America (PPFA) changed its standards to hold that qualified affiliate clinics could provide abortions by D&E through the 18th week of pregnancy. (Appendix D to this brief.) Studies examining the health impact of "hospital-only"

The ban on the performance of second trimester abortions in Akron clinics imposes a substantial burden on women needing second trimester abortions. The Sixth Circuit Court of Appeals found:

> There was unrebutted testimony that there were only two hospitals in Akron in which second trimester abortions were being performed. During the year preceding trial, [1977] only nine such abortions were performed in these two hospitals. It was testified that approximately 10% of the 6,000 women who sought abortions in the Akron clinics during the same period were in their second trimester of pregnancy. Many of these women were referred to clinics in Cleveland, Ohio, and in the State of Michigan. Those who were unable to travel to those places were faced with the choice of carrying the baby to term, attempting self-abortion, or seeking illegal abortions. The mortality and morbidity incidence of self-abortions and illegal abortions greatly exceeds that of the second trimester D&E procedure. (Pet.A. 19a.)

Furthermore, unrebutted testimony at the time of trial in 1978 established that no second trimester abortion services were available in Akron hospitals. (Gotshall, J.A. 113a.) Finally, the hospitalization rule greatly increases costs of abortion. The circuit court pointed out that, "a second trimester abortion in a hospital costs $850-$900, while total charges for a D&E abortion in a clinic are $350-$400." (Pet.A. 20a.)

These burdens fall disproportionately on teenage, poor, and minority women who are most likely to need second trimester abortions, and are least able to pay for hospitalization or travel. (Tietze, J.A. 199a-200a.) As the court of appeals concluded, "[w]ithout the ability to travel and the funds to pay for the hospital treatment, many . . . Akron women have no real opportunity to obtain an abortion." (Pet.A. 19a.)

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requirements, sponsored by the United States Centers for Disease Control and published in medical and scientific journals, endorse the safety of second-trimester abortions in clinics and state there is no reason for rigid in-hospital requirements. (L.doc. 3, p. 406/Ash.A. 85; L.doc. 8, p. 772.)

3. Section 1870.05(B) Provides No Alternative to a Parental Veto and Endangers the Health and Well-Being of Minors.

Section 1870.05(B) prohibits physicians from performing abortions for minors under age 15, unless the physician has first obtained the consent of one of her parents,[23] or the minor has obtained a court order. This requirement is contrary to the practice followed by the City of Akron in providing other medical care to minors. Parental consent or notification is not required for the prenatal care and venereal disease treatment provided by the City of Akron. (Keck, J.A. 209a-210a.)

Defendants suggest this requirement is needed because all minors under 15 are "immature." (D.Brief 5, 24.) This is simply wrong. The director of one clinic testified that 25-30% of the patients under 15 were knowledgeable and well-informed about abortion and its consequences, and more than 50% about its alternatives. (Gotshall, T.I, 186-187; see also, Hofmann, T.III, 164, 165; Heald, J.A. 132a: "there are some 14 year olds who are mature enough to make the decision.") Even defendants' own expert testified that he had some 14 year old patients who were mature enough to make a decision. (Williams, J.A. 281a.)

There is no question, however, that parental involvement helps most pregnant minors, and in fact, parents are involved in the overwhelming majority of cases. A four month survey taken in 1978 by Akron Center for Reproductive Health indicated that of the 29 women 14 years of age, 26 came with a parent; and, of the seven younger women, every one was accompanied by a parent. (Gotshall, T.I, 159-160; P.Ex. 17, J.A. 287a.)[24]

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[23] Read in conjunction with §§ 1870.06 and 1870.07, this means the parents must personally receive all the mandated information at least 24 hours ahead of the abortion procedure.

[24] The results of this survey are consistent with testimony from other facilities. See Goldberger, J.A. 143a (most patients under 17 come to Akron Women's Clinic with parents); Parker, J.A. 168a (most patients under 15 who go to Planned Parenthood for pregnancy counseling are accompanied by a parent); and Hurst, T.V, 214 (two-thirds of minors go to WomenCare with a parent.).

The few Akron teenagers who do not involve their parents have extremely good reasons for not doing so: some are afraid of "additional physical abuse," others fear harming a "terminally ill parent." (Bolitho, J.A. 153a; Goldberger, J.A. 143a.) Physical violence is particularly prevalent where pregnancy results from rape by the father. (*See* Crist, J.A. 99a.) The incidence of incest-related pregnancy in young teens is quite high. One witness testified that in a study he had done involving 400 abortion patients, of the 17 girls age 12 and under, 11 were pregnant because of incest. (Crist, J.A. 99a.)[25] Apart from situations in which there is a risk of physical violence, the experts testified that parental reactions will sometimes cause significant emotional injury to the pregnant teenager, or damage the family relationships. (Crist, J.A. 99a-100a; Heald, T.II, 82, 104; Hofmann, J.A. 159a-160a.) Furthermore, some parents will veto an abortion regardless of the best interests of the minor. (Black, J.A. 222a; Seguin, J.A. 240a.)

The irreparable effects of teenage pregnancy were recognized by this Court in *Michael M. v. Superior Court of Sonoma County*, 450 U.S. 464 (1981). A young teenager suffers from a much higher risk of mortality if she goes through pregnancy and childbirth than she does getting an abortion. (Heald, T.II, 71; J.A. 129a.)[26] It is well-documented that teenagers seek abortions later in their pregnancies than older women, and that any such delay increases health risks. (Heald, J.A. 129a-130a; Hofmann, J.A. 158a.) Because of § 1870.05(B), some young women will seek abortions in other localities, thereby increasing the risks associated with inadequate follow-up care; others will opt for illegal or self-abortion; and still others will attempt suicide. (Crist, J.A. 102a, 103a ; Heald, T.II, 83; Hofmann, J.A. 158a-159a.)[27]

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[25] An administrative assistant in the Medical Department of the Summit County Welfare Department testified that she had counseled an incestuously impregnated minor under the age of 15 in the month before trial. (Crossman, J.A. 218a.)

[26] From 1977-1978, the maternal death rate among mothers under age 15 was 18 per 100,000 live births. (Alan Guttmacher Institute, *Teenage Pregnancy: The Problem That Hasn't Gone Away* (1981); L.doc. 14, p. 29.)

[27] Approximately one-fourth of female minors who attempt suicide do so because they are, or believe they are, pregnant. (Teicher, *A Solution to the*

The most harmful effects of § 1870.05(B) may not be strictly medical. To force motherhood on a 13 or 14 year old girl, whose parents will not (or cannot) help or support her, will change her entire future. (Heald, T.II, 73-74; Crist, J.A. 110a.) Most teenage mothers do not finish high school; about 60% of mothers aged 15-17 are on welfare within two to five years of the birth of their children. *Michael M.*, 450 U.S. at 479 n.9 (Stewart, J., concurring.). And the children born to these children face greatly increased risks of death in infancy, retardation, cerebral palsy, epilepsy, and learning disability. (Crist, J.A. 110a; Heald, T.II, 74-76; Hofmann, T.III, 166-167.)[28]

4. Sections 1870.06(B) and 1870.06(C) Force the Attending Physician to Give Each Patient Distorted and Erroneous Information.

Sections 1870.06(B) and 1870.06(C) of the Akron Ordinance mandates the "attending"[29] physician to present a prepared script, and forecloses the exercise of any professional judgment. (Pet.A. 15a.)

Most women who come to the Akron clinics seeking an abortion have had both counseling and referral assistance before they ever contact the clinics.[30] At the Akron clinics, each

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Chronic Problem of Living; Adolescent Attempted Suicide, in Current Issues in Adolescent Psychiatry 129, 136 (J. Schoolar ed. 1973). *See, e.g.*, the case of a pregnant 17 year old in Ohio who attempted suicide by shooting herself in the abdomen because she did not have the $600 cash needed to pay for an abortion in a Cleveland hospital. *Suicide Attempt Failure for Teen, But Fetus Dies*, The Plain Dealer, July 28, 1979, at 5a, col. 1.)

28 The offspring of incest victims have a high likelihood of deformity and/or death, even if the parents are normal. (See Adams & Neal, *Children of Incest*, 40 Pediatrics July 1967 at 55; L.doc. 16, p. 59.)

29 The term "attending physician" used in § 1870.06 is not specifically defined. (See IIA, p. 35 n.59, *infra*.)

30 For example, Akron Center for Reproductive Health Director of Counseling, Yvonne Bolitho, testified that "approximately two-thirds to three-fourths of our patients have been seen by other professionals, and have been counseled before they come to us." (Bolitho, J.A. 151a; see also Parker,

woman is informed orally and in writing of the risks of the abortion procedure, signs an informed consent form, is instructed in techniques of birth control, and is provided aftercare instructions before the abortion is ever performed.[31] Defendants' claim that the doctor neither counsels nor consults with his patients (D.Brief, p. 10.) is contrary to the evidence. (Pet.A. 47a.) The physician performing the abortion reviews the patient's medical chart with her, talks with her about her questions and concerns, and does a pelvic examination. (Gotshall, T.I, 151; Goldberger, J.A. 139a-140a; Hurst, T.III, 13-15, 30-31.) If the doctor detects any ambivalence, he will "suggest that [the patient] return at another time, after she [has] had some additional time to consider alternatives to abortion." (Dr. Bliss, T.VII, 108; Dr. C., T.VII, p. 11-12; Gotshall, T.I, 149-150.)

Sections 1870.06(B) and .06(C) prohibit the attending physician from exercising any medical judgment to delegate birth control, welfare, or risk-counseling to other professionals. Yet,

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J.A. 168a; Crossman, J.A. 216a; Gotshall, J.A. 112a; Goldberger, T.VI, 102.) Both plaintiffs' and defendants' witnesses agreed that the vast majority of women have decided to have an abortion prior to coming to an abortion clinic. (See Heald, T.II, 115; Dr. C., J.A. 232a; Schmidt, T.X, 88.)

31 The counselors at all three clinics are experienced in family planning and pregnancy counseling. Counselors at ACRH must have a college degree, preferably in psychology or sociology, and previous experience in counseling. (Gotshall, T.I, 175.) They are trained extensively by ACRH before they are allowed to counsel patients, and they receive continuing in-service training. (Bolitho, T.III, 67.) Training includes reading medical literature on abortion, family planning and sexuality, observing counseling sessions, and counseling under the supervision of the director of counseling. (Gotshall, T.I, 129.) Each patient spends at least one hour with these counselors; part of this time is spent in reviewing the informed consent form. (Gotshall, T.I, 149.) Counselors at Akron Women's Clinic undergo similar training. In addition, a patient there does not sign the consent form until she has had an individual session with a registered nurse who explains the form to her. (Goldberger, T.II, 134-136.) At WomenCare, both a counselor and a registered nurse will review each part of the informed consent form with individual patients to insure that the patient understands each of the possible complications. (Hurst, T.III, 30-31.)

there was testimony that delegation of such counseling can better serve the needs of the patient, because doctors are not always the best equipped to do counseling, particularly in regard to an unwanted pregnancy. (Hofmann, J.A. 167a, T.III, 153; Kerenyi, J.A. 213a.)[32]

Section 1870.06(B) requires every physician to recite specific information, most of which is either irrelevant, misleading, threatening, inaccurate, or impossible to ascertain. For example, subsections 1870.06(B)(1) and (2) require that every woman be told that she is pregnant and the number of weeks that have elapsed from the time of conception; this is not always possible. These requirements would preclude doctors from performing menstrual extractions, i.e., abortions done at about four weeks of pregnancy before a pregnancy test generally can be done. (Crist, J.A. 88a.)[33]

Section 1870.06(B)(3) requires that the attending physician orally inform each patient that the "unborn child" is "a human life from the moment of conception," and describe in limitless detail the "anatomical and physiological characteristics of the particular unborn child . . . " including "appearance, mobility, tactile sensitivity. . . . " There was no medical or scientific agreement that life begins at conception,[34] and some of the

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32 The district court found that requiring doctors to do all this counseling will increase the cost of abortion. (Pet.A. 97a.) Further, there are very few physicians who perform abortions in Akron; and the few who do, have only been willing to devote a limited amount of time to performing abortions. (Goldberger, J.A. 141a-143a, 224a-225a; Bliss, J.A. 215a.)

33 The definition of abortion used by the U. S. Center for Disease Control includes menstrual extractions; "any intervention to terminate a suspected pregnancy (whether or not the pregnancy is later confirmed)." (P.Ex. 69, p. 5/T.I., 39.)

34 Theological experts testified that the particular view of the beginning of human life expressed in § 1870.06(B) is a religious one, not shared by everyone, and that being forced to say these statements would interfere with some doctors' free exercise of religion. (McKeenan, T.II, 215, 216; Weist, T.V, 131, 132; Wood, T.V, 34.) Plaintiff Dr. Bliss testified that the mandated statement about the beginning of human life was contrary to his own beliefs,

details required exceed the bounds of what is presently available from medical science.[35] Further, the medical experts testified that giving the detailed description of the fetus can be "cruel, heartless, and so overwhelming," that it is likely to produce anxiety and guilt in a number of patients. (Hofmann, T.III, 138; Heald, T.II, 88; Katz, T.IV, 113.) This description is intended to impress upon the woman that abortion is equivalent to murder.[36]

Section 1870.06(B)(4) compels the attending physician to tell each patient at every stage of her pregnancy that if more than 22 weeks of pregnancy have elapsed, "her child" might be viable, and that "her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion." Since at least 99% of abortion patients in Akron are under 14 weeks pregnant, this material is irrelevant and will confuse many women. (Katz, T.IV, 113.)

The district court found that defendants were unable to prove that the information required by § 1870.06(B)(5) was entirely true. (Pet.A. 95a.) Four of the possible "serious" complications specified in § 1870.06(B)(5) are simply unsup-

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and he would have a great deal of difficulty in complying with the requirement. (T.V, 110, 113.)

35 The district court found that it is impossible for the doctor to determine many of these required details, such as the "unborn child's" sensitivity to pain (Pet.A. 96a.), and that the "including, but not limited to," language is so vague that the physician simply cannot know how much detail to include. (Pet.A. 96a n.26.)

36 One of the defendants' witnesses explained how the mandated words will yield this result:

> "product of conception, fetal tissue, globe of protoplasm, fetal placental unit and other high sounding phrases are all direct denials of the humanity of the growing child. Make up your mind. If you are convinced that this is a human life, call it such. Then consistently speak of he or she, not it, and speak of an unborn, pre-born, or developing child or baby. It is easier to approve killing of a fetus, much more so than killing of an unborn baby." (Wilke, J.A. 277a.)

ported by any credible evidence.[37] Section 1870.06(B)(5) also forces the doctor to state that abortion is a "major surgical procedure" when, as found by the district court, abortion is generally considered a "minor surgical procedure." (Pet.A. 95a, 86a.)

Four of the eight serious complications listed in § 1870.06(B)(5) are possible, though extremely rare: hemorrhage, perforated uterus, infections, and sterility.[38] These complications are already explained to the patient and are contained in the informed consent forms. (P.Ex. 10, J.A. 285a; P.Ex. 32, J.A. 292a; P.Ex. 37, J.A. 297a.)

Subsections (6) and (7) of § 1870.06(B) require the physician to tell every woman that numerous public and private agencies are available to help her with birth control, prenatal care and adoption, and to provide help after "the birth of her child." The doctor is not an expert on these matters, nor is it always true that such help is actually available.[39]

The requirements distort the goal of informed consent, which is intended to give patients information so that they can have a "greater role to play in the medical, decision-making process." (Katz, J.A. 190a.) Subsections 3, 4, and 5 constitute

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37 Aside from extremely rare occurrences, there is no medical evidence that abortion causes "menstrual disturbances," "miscarriage and prematurity in subsequent pregnancies," and "severe emotional disturbances." (Crist, T.I, 76; Katz, T.IV, 114-115; Tietze, T.IV, 155-156.) Medical studies subsequent to the trial of this case find no increase in the risk of miscarriage or prematurity subsequent to abortion. (L.doc. 13, p. 551, L.doc. 11, pp. 83-84.) For women with existing psychological problems, "relief far exceeds the number of difficulties." For healthy women, the risk of post partum depression is five times higher than the risk of psychiatric disturbance following abortion. (David, T.IV, 62-66; Bliss, T.V, 113.)

38 The complication of "sterility" is presented in a misleading way. Sterility is not a separate complication. It arises as a complication from an infection or because a hysterectomy was performed as a treatment for an uncontrolled hemorrhage. (Tietze, T.IV, 153-155.)

39 Some of the Akron abortion patients are referred to the clinics after being counseled at the Summit County Welfare Department (Crossman, J.A. 216a.), where they may have learned that no help is available.

a one-sided presentation of all the possible (and impossible) risks, physical and psychological, of an abortion. Nowhere is the p[illegible] informed that the risks of an abortion are much less than the risks of a continued pregnancy. (Crist, T.I, 78; Heald, T.II, 97.) Thus, the informed consent dialogue is transformed into an anxiety-producing ordeal for the woman, and the doctor becomes the enemy of his patients by being forced to articulate "distasteful" and "dishonest" propositions. (Crist, J.A. 106a; Katz, J.A. 193a.) The requirements of §§ 1870.06(B) and (C) do not allow the physician, under any circumstance, to exercise any medical, professional judgment to forego some of the information, either at the patient's request or on the basis of his own good sense.[40] Defendants' experts agreed on the need for such flexibility, and stated that they would not personally force information on a woman. (Seguin, J.A. 238a-239a; Sim, J.A. 274a-275a; Wilke, J.A. 276a; Schmidt, T.X, 53.) The district court found that the inflexibility of these requirements places the physician in the " 'undesired and uncomfortable straitjacket' warned against by the Supreme Court." (Pet.A. 96a.)

5. The Inflexible 24 Hour Waiting Period Senselessly Imposes Physical, Emotional, and Economic Burdens on Women Needing Abortions in Akron.

Section 1870.07 mandates a 24 hour delay between the time a woman signs the consent form and performance of the abortion. The waiting period is designed to work in conjunction with § 1870.06; every patient is required to wait at least 24 hours to "mull over the information she receives during counseling." (D.Brief, p. 47.)

The court of appeals found that the defendant presented no evidence "that an inflexible requirement of a 24-hour waiting

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[40] Dr. Katz testified that, in the interest of preserving patient health and well-being, it is sometimes medically appropriate to go forward without detailing all the risks, and that there are studies that indicate between 11-17% of all patients do not want to know "a great deal about what is in store for them." (J.A. 190a-191a.)

period for an abortion serves any interest of the state." (Pet.A. 17a.) The defendants' medical witnesses only testified about the waiting period that ordinarily occurs prior to in-hospital surgery, and did not relate this practice to the procedures involved in early abortions. (Pet.A. 17a.)

Defendants did not dispute the fact that the 24 hour waiting period can result in significantly longer delays. Plaintiff clinics perform abortions only two or three days a week. Thus, most women will actually be forced to wait two to four days, and for one week or more if they require general anesthesia, which is offered by one clinic only once a week. (Gotshall, J.A. 115a-116a.)

Defendants attempt to minimize the health risks created by this requirement by terming them "not critical" (D.Brief, p. 12.), and by ignoring the unrebutted proof that the wait could never be just 24 hours in Akron. The actual two to seven day delay resulting from the 24 hour waiting period requirement poses a serious health risk to women seeking abortion, because it multiplies morbidity and mortality risks (Tietze, J.A. 201a-202a; P.Ex. 75, p. 1/T.III, 212, 213.), and, as Dr. Crist testified, delays approaching a week can present a "real physical health hazard." (T.I, 70.)

Defendants totally ignore the serious mental health risks to some women (D.Brief, p. 12.), the possibility of which is noted by Judge Kennedy in her Sixth Circuit opinion. (Pet.A. 36a.) Dr. Crist testified that, in terms of psychological health, a 24 hour delay would be a very significant contribution to the "great emotional problem that women seeking abortions face," which is the "agony between making the decision and having the procedure done." (T.I, 70.) Imposing an inflexible waiting period causes increased anxiety, and constitutes callous disregard for the mental well-being of rape and incest victims. (Crist, J.A. 108a; Katz, T.IV, 127-128.) In some cases, this mandatory waiting period "will tip [a woman] to doing drastic things, such as self-abortion. . . ." (Crist, J.A. 108a.)

The mandated delay will also impose serious financial burdens on women seeking abortions. The district court found that the 24 hour waiting period makes abortions more expen-

sive by requiring the patient to make "two trips to the clinic instead of one,"[41] and by making the "cost of the procedure itself more expensive" by increasing the time the physician must spend with each patient. (Pet.A. 98a.) In addition to doubling the cost of travel, two trips will mean additional childcare costs and loss of pay from work. (Goldberger, J.A. 223a-224a.)

There was no evidence that women who seek abortions make hasty or ill-advised decisions, or that a waiting period enforced by criminal penalties will "actually benefit" women. (D.Brief, p. 47.)[42] On the other hand, plaintiffs demonstrated that the 24 hour waiting period would impose serious burdens on women seeking abortions.

SUMMARY OF ARGUMENT

I.

The criminal provisions severely limiting abortions enacted by the Akron City Council should be closely scrutinized by this Court because they have a significant impact on fundamental

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41 The issue of travel costs is serious, because as many as three out of every four patients at the plaintiff clinics are from outside the City of Akron. (Goldberger, J.A. 223a; Gotshall, T.I, 171.)

42 The one published study of the effects on abortion patients of a mandatory 48 hour waiting period was done in Tennessee in 1979-1980, prior to the injunction against the Tennessee law. Two surveys were made of some 400 women about the benefits and drawbacks of the waiting period. In the first survey, more than seven out of ten women were unable to name a single benefit derived from waiting, and six in ten pointed to one or more problems, including: extra expense; missed work or school (41% of all jobholders reported losing an average of $32.00 in pay because of the required second visit); and entering the second trimester. In the second survey one group of women was interviewed before and after the waiting period to see whether their attitudes toward it changed. The results showed that women realized fewer benefits and more problems from the wait than they had anticipated. Sixteen percent of the women had initially named an expected benefit from the wait; this dropped to 7% at the end of the required wait. (Lupfer & Silber, *How Patients View Mandatory Waiting Periods for Abortion*, 13 Fam. Plan. Persp. 75 (1981), L.doc. 17, pp. 75-79.)

privacy rights protected by the Constitution. This Court held in *Roe v. Wade*, 410 U.S. 113, 153 (1973), that the right to decide whether or when to bear a child is a critical part of the constitutional right of privacy guaranteed by the due process clause of the Fourteenth Amendment. The decision in *Roe v. Wade* incorporating the standards of strict judicial scrutiny that apply when fundamental rights are impinged upon by government restrictions, was carefully followed by the Sixth Circuit Court of Appeals. Defendants did not meet their burden of showing that the regulations fulfill any compelling, or even less than compelling, state interests. In fact, two of the named defendants, the mayor of the City of Akron and the director of the health department, frankly admitted that there were no health or safety reasons for the restrictions.

II.

Sections 1870.06(B) and (C) of this municipal ordinance dictate what every doctor must tell every woman seeking an abortion, even in the case of medical emergencies. The ordinance mandates that doctors not only communicate medical risks, a requirement already established by state law, but also that doctors orally present welfare information, medical misinformation, and inflammatory and threatening statements designed to make a woman feel that abortion is murder. This puts a doctor in a "straitjacket" and burdens a woman's decision-making process. *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 67 n.8 (1976). Furthermore, this section offends the very essence of the First Amendment because it forces the doctor to be the affirmative sponsor "of particular ethical or religious beliefs," which is something "we expect the state not to attempt in a society constitutionally committed to the ideal of individual liberty and freedom of choice." *Bellotti v. Baird*, 443 U.S. 622, 638 (1979).

III.

Section 1870.07 of the ordinance proscribes abortion until every woman has waited 24 hours from the time she has received the information dictated by § 1870.06(B) and (C).

Defendants did not show how this requirement, as applied to every woman, would actually promote a compelling, or even legitimate, state interest. The physical, emotional, and economic burdens that would be created by forcing every woman to make two trips, and inevitably wait more than 24 hours, were established.

IV.

Section 1870.03 requires that every abortion after twelve weeks take place in a hospital. Defendants did not prove that this regulation was narrowly tailored to promote maternal health interests. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976). At the time of trial, no second trimester abortions were available in hospitals in Akron. Furthermore, medical advances have made early second trimester abortions as safe in clinics as in hospitals and, in fact, the majority of early second trimester abortions in this country are performed in clinic facilities. The Sixth Circuit upheld § 1870.03 only because of this Court's summary affirmance in *Gary-Northwest Indiana Women's Services v. Orr,* 451 U.S. 934 (1981), a case involving a different statute and presented to this Court in a different procedural context.

V.

Section 1870.16 requires "humane and sanitary" disposal of fetal tissue. This requirement is void for vagueness under the due process clause of the Fourteenth Amendment. Defendants ask that this Court reconstruct the sentence by severing the word "humane," but to do so would clearly be contrary to legislative intent. *Champlin Refining Co. v. Corp. Commission of Oklahoma,* 286 U.S. 210, 234 (1932).

VI.

Defendant City of Akron did not appeal the parental consent requirement, § 1870.05(B), to the Sixth Circuit Court of Appeals (Pet.A. 11a.) and for that reason should be precluded from appealing it to this Court. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 783 n.14 (1980). Furthermore,

the defendant-intervenors demonstrated no Article III standing requisite for appellate resolution. *Barry v. District of Columbia Board of Election and Ethics,* 580 F.2d 695 (D.C. Cir. 1978). They did not allege their daughters were sexually active, likely to become pregnant, or likely to seek an abortion. In addition, by the time of the Sixth Circuit appeal, both daughters were over age 15, and could not be affected by § 1870.05(B). *Roe v. Wade,* 410 U.S. at 127-129; *Craig v. Boren,* 429 U.S. 190, 192 (1976).

On the merits, § 1870.05(B) is unconstitutional because it gives parents or a court an effective veto over the minor's abortion. *H.L. v. Matheson,* 450 U.S. 398, 413-420 (1981) (Powell, J., concurring); *Bellotti v. Baird,* 428 U.S. 132 (1976). There is no way for mature or "best interests" minors to avoid parental consultation. As found by the district court (Pet.A. 93a.), the state juvenile court rules require both parents to be notified in every case. Because of its limited jurisdiction, juvenile court can order medical care only on a "best interests" standard after both parents have been adjudged neglectful; it cannot issue an adjudgment of maturity. As admitted by defendants, the Akron City Council has no authority to change jurisdictional rules of a state court. (D.Brief, p. 27.)

ARGUMENT

I.

CONSISTENT WITH PRINCIPLES OF JUDICIAL REVIEW, THE SIXTH CIRCUIT COURT OF APPEALS CORRECTLY APPLIED THIS COURT'S STANDARD FOR REVIEWING STATUTES WHICH IMPINGE UPON FUNDAMENTAL PRIVACY RIGHTS.

A. This Court Has Consistently Applied the Compelling State Interest Test Established in *Roe v. Wade.*

In *Roe v. Wade,* 410 U.S. 113, 153 (1973), this Court held that the "right to privacy, . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon

state action, . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." State interference with fundamental rights can be justified only by a "compelling state interest," and a showing that the regulations are narrowly drawn to serve those interests. *Id.* at 155.[43] Those state interests are (1) protecting the health of the pregnant woman, which does not become "compelling" until the second trimester of pregnancy and (2) protecting potential life, which does not become "compelling" until the fetus is considered by the physician to be viable. *Id.* at 162-163. Therefore,

> for the period of pregnancy prior to this 'compelling' point, the attending physician in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State. *Id.* at 163.

This Court has reaffirmed the *Roe* formulation in subsequent decisions; legislation which interferes directly with the abortion right is subject to strict scrutiny. Such laws are unconstitutional if they are not narrowly drawn to serve one of the compelling state interests set forth in *Roe*.[44] For instance, *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) struck down a statutory prohibition against the use of saline amniocentesis as an abortion technique after the first 12 weeks of pregnancy. This Court found that it did not

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[43] Regulations applicable to first trimester abortions are almost always invalid, since no compelling state interest exists at that stage. *Doe v. Bolton*, 410 U.S. 179, 195 (1973). *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) underscored that first trimester regulations which "restrict" abortion are permissible only if they insure the existence of the medical standards which underlie the finding in *Roe* of the safety of first trimester abortions.

[44] Laws impinging on fundamental rights are "presumptively unconstitutional." *Harris v. McRae*, 448 U.S. 297, 312 (1980). Once plaintiffs show the requisite degree of interference, defendants bear the burden of proving the law is narrowly tailored to further a compelling state interest. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 76-77 (1976); *Doe v. Bolton*, 410 U.S. at 195.

promote the state's interest in maternal health because abortion by that method was still safer than childbirth, and alternative abortion methods were not yet widely available. This Court further found that the requirement was not narrowly drawn, since other, more dangerous methods were not prohibited. *Id.* at 76-77. *See also Colautti v. Franklin,* 439 U.S. 379 (1979); *Carey v. Population Services International,* 431 U.S. 678, 686 (1977).[45]

As the Sixth Circuit correctly stated, the standard of review set forth by this Court requires a two-step analysis. If the regulation causes no legally significant impact on the abortion decision, it does not trigger strict scrutiny.[46] If it does impose a significant burden on first trimester abortions, the requirement is unconstitutional. For post-first trimester abortions, a regulation must be examined to determine whether it serves one of the two compelling state interests, and if it does, whether the burden is "undue," i.e. it is sufficiently narrowly drawn. (Pet.A. 10a.)[47]

This Court's rulings on the privacy rights of minors do not conflict with this standard. *Bellotti v. Baird,* 443 U.S. 622, 633

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45 Strict scrutiny analysis need not be employed when a regulation causes no significant burden. The *Danforth* Court upheld a record-keeping requirement because it had "no legally significant impact or consequence on the abortion decision." 428 U.S. at 80-81. Similarly, an informed consent requirement, which did not specify the content of the physicians' speech, was found not to interfere with the abortion decision. *Id.* at 77.

46 The decisions on public funding for abortions are not inconsistent with this analysis, since such restrictions, unlike laws which constitute "direct state interference with a protected activity," have been held to be "state encouragement of an alternative activity." *Maher v. Roe,* 432 U.S. 464, 474-475 (1977); *Harris v. McRae,* 448 U.S. 297, 314 (1980).

47 Defendants confuse "undue burden" with "burden." (D.Brief, p. 19.) This Court has used the phrase "undue burden" only to describe the ultimate constitutional determination following the application of one of the two possible standards of review. *See Maher v. Roe,* 432 U.S. at 470; *Carey v. Population Services International,* 431 U.S. at 686; *Bellotti v. Baird,* 428 U.S. 132, 147-148 (1976). Only the showing of a "burden" is necessary to invoke strict scrutiny. By using the phrase "undue burden," this Court has not suggested that the *Roe* framework has been replaced by a standardless balancing test.

(1979) recognized that "the status of minors under the law is unique in many respects." Thus, "the State has somewhat broader authority to regulate the activities of children than of adults," *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 74-75, because there are state interests at stake which are not present in the case of adults.[48]

B. Strict Scrutiny Provides a Clear Standard of Review.

Defendants ask this Court to reverse its established principle of utilizing strict scrutiny to analyze restrictive abortion laws and substitute a confusing and unmanageable ad hoc approach.[49] They advocate adoption of the standards of review used by the dissenting judge in the court of appeals and by the district court, which balanced the degree of interference with the abortion right against the importance of the interest asserted by the state. (D.Brief, p. 18, 21-22.) The problems that such an approach would create for lower courts and litigants are illustrated by the opposite results reached by those two judges as to the constitutionality of the 24 hour waiting period. The district court weighed the degree of interference caused by the waiting period against the asserted state interest and concluded that, although the requirement would create an increase in cost, this burden did not outweigh the "important" state interest in "insuring" that the woman consider her decision carefully. (Pet.A. 98a-99a.) Judge Kennedy, concurring with the majority, found the provision unconstitutionally overbroad because it posed "a grave risk to the mental health" of some women and created "such significant extra expense . . . as to

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[48] This Court has applied a similar two-step analysis in cases involving minors, inquiring whether or not a burden is imposed, and if so, applying a level of judicial scrutiny that requires the law to be narrowly drawn to further "significant" or "important" state interests, such as promoting parental involvement in the abortion decision. *H.L. v. Matheson,* 450 U.S. 398, 411-413 (1981); *Carey v. Population Services International,* 431 U.S. at 692-696; *Bellotti v. Baird,* 428 U.S. at 148.

[49] The clarity of this constitutional standard for abortion cases is reflected in the uniformity of the substantive results in the circuit courts of appeal which have considered challenges to restrictive abortion laws similar to the Akron ordinance. (See footnotes 57, 64, *infra.*)

unduly burden if not effectively prohibit," the abortion rights. (Pet.A. 36a.)

If this Court substituted a balancing test for strict scrutiny, lower courts would be left to speculate—and would inevitably disagree—on how to weigh an asserted state interest and how to evaluate the degree of the interference with the abortion decision.[50] Plaintiffs challenging such laws would never know the measure of proof necessary to satisfy a test for burdensomeness. The clarity and predictability of the present standard of review for abortion restrictions would be lost.

C. It is Essential For Federal Courts to Safeguard Constitutional Rights.

Marbury v. Madison, 5 U.S. (1 Cranch) 137 (1803), established the fundamental principle of judicial review, which holds that the Court, and not the legislature, is the final arbiter on matters of constitutional interpretation. This power of the Court "to say what the law is," *id.* at 177, allows the judiciary to act as a check on the legislative and executive branches of government, and to safeguard individual rights. The brief *amicus curiae* of the Solicitor General urges this Court to depart radically from this tradition, and to defer to state and local legislatures in matters involving abortion.[51] The Solicitor General suggests that this is appropriate because abortion is an area in which policy and constitutional principles "overlap," and because the right to choose abortion, like other privacy

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50 In *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 343 (1974) this Court rejected just such a case-by-case balancing with respect to interests protected by the First Amendment because such an "approach would lead to unpredictable results, and uncertain expectations, and it could render our duty to supervise the lower courts unmanageable." *Id.*

51 The Office of the Solicitor General made the claim in *Goldsboro Christian Schools, Inc. v. United States*, 436 F. Supp. 1314 (E.D. N.C. 1977), *cert. granted*, 50 U.S.L.W. 3278 (U.S. Oct. 13, 1981) (No. 81-1), that the Commissioner of Internal Revenue could not promote the fundamental national policy against racial discrimination. There, as here, the Solicitor General sought to reverse a long-standing tradition of enforcing fundamental rights in order to pursue a narrow political goal.

rights, is merely a "shadow" right, not explicitly protected by the Constitution. (S.G.Brief, pp. 11, 19.)

This Court has recognized that certain rights are so fundamental and "implicit in the concept of ordered liberty," as to be contained within more explicit guarantees of the Constitution. *Palko v. Connecticut,* 302 U.S. 319, 325 (1937). *Roe v. Wade,* 410 U.S. at 152-153, held that the right of privacy founded in the Fourteenth Amendment's concept of personal liberty, "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." The State's power to interfere with fundamental privacy rights is limited. *Paul v. Davis,* 424 U.S. 693, 713 (1976). The extent to which the abortion decision can be regulated, therefore, is not a matter of "choosing among competing policy alternatives" (S.G.Brief, p. 11), but rather one of protecting a constitutional right from infringement by political majorities.[52]

The Solicitor General argues that, because of the intensity of the abortion debate, abortion proponents and opponents should be left free to fight it out in the political arena. But it is precisely when popular sentiment runs highest that majoritarian institutions are the least reliable guarantors of individual rights. *See United States v. Carolene Products Company,* 304 U.S. 144, 152 n.4 (1938). As Justice Jackson eloquently stated in *West Virginia State Board of Education v. Barnette,* 319 U.S. 624, 638 (1943):

> "The very purpose of a Bill of Rights was to withdraw certain subjects from vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by

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52 The Solicitor General argues that the legislature has "superior fact-finding capability" and that the quality of the "product" is enhanced by leaving "the issue exposed . . . to the legislative process." (S.G.Brief, pp. 12-13.) The record in this case effectively rebuts this argument. It was undisputed that the Akron ordinance was designed to be a model "anti-abortion" ordinance. Its drafters were ignorant of the excellent record of the clinics. Furthermore, the issue was "exposed" at a secret hearing and voted on before all the council members were given a copy of the final text. The mayor of Akron refused to veto or sign this bill, stating that on issues such as this the courts are the place for "proper resolution." (See p. 5, *supra.*)

> the courts. One's right to life, liberty, . . . freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections."

The judicial standard suggested by the Solicitor General would effectively bar courts from carefully scrutinizing legislation having significant impact on fundamental rights. This shift would undercut *Roe*'s recognition of the fundamental nature of the abortion right, leaving it vulnerable to unreviewable legislative control. If deference is paid to state and local legislatures in the abortion context, there is no reason why other fundamental rights, such as the right to vote, should not be accorded the same treatment. Yet history teaches otherwise. *Brown v. Board of Education of Topeka,* (*Brown* I), 347 U.S. 483 (1954) which declared *de jure* school segregation unconstitutional, was met with passionate local resistance in many areas of the country. This Court responded by ordering school officials to comply with its ruling and declared "the vitality of these constitutional principles cannot be allowed to yield simply because of disagreement with them." *Brown v. Board of Education of Topeka,* (*Brown* II), 349 U.S. 294, 300 (1955). *See also Cooper v. Aaron,* 358 U.S. 1 (1958).[53]

Given that *Roe v. Wade* is the law of the land, as the Solicitor General concedes, it is the duty of this Court to uphold the constitutional rights guaranteed therein. Protection of individual liberties is never more important than when they are most imperiled.

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[53] As Justice Frankfurter stated:

> The Constitution is not the formulation of the merely personal views of members of the Court, nor can its authority be reduced to the claim that state officials are its controlling interpreters. Local customs, however hardened by time, are not decreed in heaven. Habits and feelings they engender may be counter-acted and moderated. Experience attests that such local habits and feelings will yield, gradually though this be, to law and education.

358 U.S. at 24-25 (Frankfurter, J., concurring)

II.

THE AKRON ORDINANCE RESTRICTIONS VIOLATE A WOMAN'S RIGHT TO PRIVACY WHICH ENCOMPASSES HER RIGHT TO CHOOSE ABORTION.

A. The Forced Speech Requirements of Sections 1870.06(B) and (C) Distort the Decision-Making Process and Unconstitutionally Burden the Abortion Decision.

Section 1870.06(B) of the Akron ordinance mandates that the "attending physician," under threat of criminal penalty, recite prescribed words to every woman seeking an abortion; § 1870.06(C) goes on to require the attending physician to inform every woman "of the particular risks associated with her own pregnancy and the abortion technique to be employed." (See Facts, pp. 15-20, *supra.*) These requirements unconstitutionally burden a woman's right to choose abortion by intruding into the physician-patient relationship, forcing the physician to say things "regardless of his own professional judgment as to the desirability of doing so" (Pet.A. 15a.), and preventing him from delegating certain parts of the counseling to others.

This Court noted in *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52, 67 (1976) that "[t]he decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." Section 1870.06(B) precludes the informed consent envisioned in *Danforth* by distorting the true nature and consequences of abortion. The ordinance destroys the flexible situation in which the patient's needs are taken into account, and forces the doctor to give false, misleading, and emotionally abusive information, designed to control the decision-making process by "skew[ing] the choice" against abortion. *See Planned Parenthood League of Massachusetts v. Bellotti,* 641 F.2d 1006, 1017 (1st Cir. 1981).[54]

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[54] Defendants concede the unconstitutionality of § 1870.06(B), (3), (4), and (5) (D.Brief, p. 37), and argue for severance, so that .06(B)(1), (2), (6),

The defects of § 1870.06(B) are obvious (See Facts, pp. 15-20, *supra.*); but .06(C) is equally objectionable. While in most cases the informed consent dialogue will include a discussion of the risks of abortion, continued pregnancy, and childbirth,[55] there are cases in which disclosure of some risks may be detrimental. The requirements preclude operation of "therapeutic privilege," which recognizes that in some cases, a physician need not disclose all information, either because the woman requests not to be told, or because he deems it to be in her best interests. (See Facts, p. 20 n.40, *supra.*)[56]

Because it is possible to create burdensome obstacles to abortion in the guise of promoting informed consent, this Court has recognized that such requirements must not be too rigid or specific, "confin[ing] the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 67 n.8.[57] Physicians must be allowed to

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and (7) can be saved. The question is whether the valid sections standing alone would "create a program quite different from the one the legislature actually adopted." *Sloan v. Lemon,* 413 U.S. 825, 834 (1973). *See also Champlin Refining Co. v. Corp. Commission of Oklahoma,* 286 U.S. 210, 234 (1932). The district and circuit courts refused to rewrite § 1870.06(B) by severing some subsections. (Pet.A. 14a-15a, 96a.) Moreover, subsections (1), (2), (6), and (7) are no less impermissible. Subsections (1) and (2) would preclude doctors from performing menstrual extractions; subsections (6) and (7) would require the doctor to make certain representations about social welfare services which may not be true and which are not within the realm of medical expertise. (Facts, pp. 15-20, *supra.*)

55 The ordinance does not contemplate an evenhanded discussion of medical risks. Section 1870.06(C) requires that the physician discuss the risks of the woman's own pregnancy only in relationship to "the abortion technique to be employed," not in relation to the risks of continued pregnancy and childbirth.

56 The informed consent requirements must be followed even in cases of life-threatening emergencies. (See § 1870.12.)

57 Circuit courts have consistently agreed that statutes which attempt to dictate rigid informed consent requirements burden a woman's right to choose abortion. *Planned Parenthood League of Massachusetts v. Bellotti,* 641 F.2d 1006 (1st Cir. 1981); *Planned Parenthood Ass'n of Kansas City, Missouri v. Ashcroft,* 655 F.2d 848 (8th Cir. 1981); *Akron Center for*

exercise discretion, not because of any constitutional right to practice medicine, but because such restraints may make it impossible for the woman to exercise her right to choose whether or not to bear a child.

> The constitutional right vindicated in *Doe [v. Bolton,* 410 U.S 179 (1973)] was the right of a pregnant woman to decide whether or not to bear a child without unwarranted state interference. The statutory restrictions on the abortion procedures were invalid because they encumbered the woman's exercise of that constitutionally protected right by placing obstacles in the path of the doctor upon whom she was entitled to rely. . . . *Whalen v. Roe,* 429 U.S. 589, 604 n.33 (1977).

Because medical treatment, medical decision-making, and the patient-physician relationship are inherently complex, the law in Ohio already recognizes that the physician must have leeway to tailor the information necessary for informed consent.[58]

Reproductive Health v. City of Akron, (Pet.A. 1a-36a); *Women's Services, P.C. v. Thone,* 636 F.2d 206 (8th Cir. 1980) *vacated and remanded,* 452 U.S. 911 (1981); *Charles v. Carey,* 627 F.2d 772 (7th Cir. 1980).

58 Ohio Rev. Code Ann. § 2317.54 (Baldwin 1981), "Patients Informed Consent," entitles physicians to a legal presumption that informed consent has been obtained if its provisions are followed. (J.A. 329a-331a.) Under this statute, a legally valid consent to medical treatment need only set forth "in general terms the nature . . . of the procedure" and its "reasonably known risks." (J.A. 330a.) The original 1975 version of the law included a detailed form which had to be used in order to trigger the presumption. Ohio Rev. Code Ann. § 2317.54 (Page 1975). The 1977 amendment deleted the form in order to allow even greater physician flexibility. Ohio Rev. Code Ann. § 2317.54 (1977, deleting subparagraph D.) Because § 2317.54 creates a presumption in malpractice actions for doctors who comply with it, rather than mandating a specific procedure to be followed throughout the state, the Akron ordinance may not directly conflict with state law. *See In Re Decertification of Eastlake,* 66 Ohio St.2d 363, 422 N.E.2d 598 (1981). However, it is clear that the Ohio legislature's twice-affirmed policy of assuring physicians flexibility and respecting their discretion is diametrically opposed to the rigidity of the Akron ordinance. Finally, the ordinance is flatly inconsistent with Ohio Admin. Code § 3701-47-06, issued by the State Department of Health to govern second trimester abortions, stating that counseling of abortion patients shall be "non-judgmental, regardless of the

Sections 1870.06(B) and (C) require that the "attending physician" personally communicate to the woman the prescribed "facts."[59] If physicians were forced to personally do all counseling, fewer women could receive the strictly medical services which only doctors may provide. In Akron, physicians have delegated a substantial portion of the intensive, time-consuming informed consent and pregnancy counseling to professionally trained counselors. (Facts, p. 16, *supra*.) The district court found that prohibiting physicians from delegating a portion of the counseling responsibility increases costs. (Pet.A. 97a.) Given the limited numbers of doctors available to do abortions, this prohibition would restrict access to services. In addition, it prevents the physician from exercising judgment that delegation of such counseling would best serve the patient's needs.[60]

Furthermore, the attending physician requirement does not promote any interest in maternal health. Defendants failed to

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circumstances of the pregnancy, but shall not be forced on the woman." (P.Ex. 45, J.A. 299a.) *See also, Rhodes v. Doctors Hospital North*, 18 O.O.3d 391, 394 (Ct. App. Franklin Cty. 1980).

[59] The term "attending physician" used in § 1870.06 is not specifically defined, nor do the lower court opinions address whether this means the same physician who is to perform the abortion. The use of the modifying phrase "performing or inducing the abortion" in § 1870.06(D) could be read to imply that a physician different from the one doing the counseling will comply with § 1870.06(D)'s requirement. On the other hand, it defies common sense to think that one doctor will perform the duty referred to in § 1870.06(D), providing the pregnant woman with a duplicate copy of the signed consent form, after a different doctor has done the counseling. The district court posits an arrangement whereby a physician would counsel some women on the same day he performs abortions on other "previously counseled" women. The court, however, does not state whether the women were to have been previously counseled by the same physician. (Pet.A. 98a n.29.) Judge Kennedy speaks in terms of "a physician," implying that one physician may do the counseling and another may perform the procedure. (Pet.A. 35a-36a.) Defendants do not even claim that the state's interest in promoting maternal health would be furthered by having the same doctor perform the counseling and the abortion procedure.

[60] Plaintiffs' evidence showed that many doctors believe that specially trained counselors are better able to counsel the woman seeking an abortion than are doctors who may have no such training. (See Facts, pp. 16-17, *supra*.)

establish or even explain why doctor counseling would better serve the medical needs of women.[61] By contrast, plaintiffs presented abundant evidence of the high standard of medical care provided by plaintiff clinics, the reasonableness of physicians' judgment to delegate some counseling, and the fact that doctors made sure that the patients are giving a fully informed consent. (Facts, pp. 15-20, *supra*.)

Sections 1870.06(B) and (C) also violate the First Amendment. As the preamble to the ordinance makes clear (Pet.A. 115a, 116a.), the purpose of these requirements is to impress upon the woman the idea that the fertilized ovum is a human being from the moment of conception, and that abortion is murder.[62] The physician is compelled to make certain pronouncements for the state with which he might profoundly disagree. (Facts, p. 17, *supra*.) As this Court has observed, "where the State's interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the courier for such message." *Wooley v. Maynard,* 430 U.S. 705, 717 (1977). *See also, West Virginia Board of Education v. Barnette,* 319 U.S. 624, 642 (1943).

The dictated counseling requirements would place anti-abortion speech in a preferred position to the neutral information now provided. Content-based regulation of speech requires the

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61 The testimony of the defendants' witnesses, in fact, was equivocal as to whether or not physicians should be allowed to delegate counseling duties. (Schmidt, T.X, 25.)

62 The requirement of § 1870.06(B)(3) that the physician tell the woman that "the unborn child is a human life" offends the physician's and woman's rights under the free exercise clause, in that it requires the physician to make, and the woman to hear what is, for many people, a statement of religious belief. The woman who may have made the abortion decision on the basis of her own moral or religious convictions is similarly forced to listen to words denigrating the legitimacy of her beliefs. Furthermore, parents must accompany their minor daughters under age 15 to the session dictated by §§ 1870.06(B) and (C). (See § 1870.06(A).) Parents who do not share the beliefs expressed in these sections would be forced to listen with their daughters to certain "truths" which may be contrary to their beliefs, and the beliefs and values they are trying to teach their children. *See Wisconsin v. Yoder,* 606 U.S. 205 (1972).

strictest scrutiny. *See Carey v. Brown,* 447 U.S. 455, 461-62 (1980). The impermissibility of this particular forced speech is underscored by this Court's admonition that the state cannot adopt one "theory of life" that overrides a woman's privacy right. *Roe v. Wade,* 410 U.S. at 162.

The First Amendment also protects a right to listen and receive information, *see Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.,* 425 U.S. 748, 756-57 (1976), and it is undisputed that this includes information about abortion. *Bigelow v. Virginia,* 421 U.S. 809, 821-22 (1975). The informed consent session, however, is not a public forum in which conflicting ideas freely compete. The woman listening to the required litany is in every sense a captive audience. If she does not go through the required counseling, she will be unable to obtain an abortion. Because she has no choice but to listen, her right not to receive information must be especially protected. *See Kovacs v. Cooper,* 336 U.S. 77, 86-87 (1949); *Public Utilities Commission v. Pollak,* 343 U.S. 451, 468 (1952), (Douglas, J., dissenting).

B. The Mandatory Waiting Period in Section 1870.07 Promotes No State Interest and Would Cause Serious Hardships.

Defendants concede that the mandatory waiting period imposes a "restriction" on a woman's "access to an abortion." (D.Brief, p. 47.) Regulations placing such legally significant obstacles on first trimester abortions are unconstitutional. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 61. Even as applied to second trimester abortions, any state interest in assuring the patient's informed consent is fully satisfied by Ohio's statutory and case law requiring disclosure of medical risks. (See Sec. IIA, p.34 n.58, *supra.*; *Siegal v. Mt. Sinai Hospital,* 62 Ohio App.2d 12, 403 N.E.2d 202 (1978).)

The waiting period imposes a medically unnecessary delay, creates risks to a woman's physical and psychological well-being, and significantly increases the cost of abortion. (See Facts, pp. 21-22, *supra*; L.doc. 8, p. 721.) The court of appeals held that the regulation was unconstitutional, not only because it

imposes a burden on abortions during the first trimester, but also because defendants failed to establish how an inflexible waiting period imposed on all women promotes "any interest of the state, much less a compelling interest." (Pet.A. 17a, *see also* Pet.A. 36a, Kennedy, J., concurring.)[63]

The 24 hour delay is not narrowly tailored. It applies to the woman obstetrician-gynecologist seeking an abortion, to the woman who has been fully counseled by her family physician, and to the woman for whom the delay would cause "such significant extra expense as to unduly burden, if not effectively prohibit, the decision." (Pet.A. 36a, Kennedy, J., concurring.) Section 1870.12 allows an exception only for physical health considerations; therefore the waiting period would apply "even where the delay would impose a grave risk to the mental health of the pregnant woman" (Pet.A. 36a, Kennedy, J., concurring), such as when the woman is a victim of rape or incest.

This statute creates an irrebuttable presumption that every woman needs to wait 24 hours after signing the consent form in order to make an informed and considered decision. The majority of women seeking abortions, however, have already made the personal and moral decision to have an abortion. The question of whether or not to bear a child is a life planning decision. For many women, it is not an issue which arises suddenly upon confirmation of pregnancy. Some women know they cannot feed or clothe any more children; others have decided they would not bear a severely deformed child.

Most women have already been counseled before going to the plaintiff clinics. Women who have not been counseled and need time to think are encouraged to wait. (Facts, pp. 15-16, *supra*.) A recent study found that, while the majority of women decide within 24 hours after receiving confirmation of

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63 Defendants did not meet their burden of proving that the requirement serves the asserted interest of protecting health. As the court of appeals found, the defendants' medical witnesses only testified about the waiting period that ordinarily occurs in general in-hospital surgical practice and did not relate these to the procedures involved in the early stages of pregnancy. (Pet.A. 17a.) The only favorable impact of the waiting period identified by defense witnesses was that it could provide a time to reflect. There was no evidence that women would "actually benefit." (D.Brief, p. 47.)

their pregnancy, some women wait as many as 75 days before deciding. (L.doc. 17, p. 76.)

The waiting period frequently exceeds 24 hours. This Court has recognized that "[t]ime, of course, is critical in abortion," and unnecessary delays are a legitimate concern to those needing abortions. *Doe v. Bolton*, 410 U.S. 179, 198 (1973). Seven circuit courts and eleven district courts[64] have concurred with the circuit opinion in this case and have either preliminarily or permanently enjoined waiting periods of 24 or 48 hours.[65]

The regulation also interferes with the woman's right to independent decision-making. *Whalen v. Roe*, 429 U.S. at 599-600.[66] The court of appeals found that the actual purpose

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64 See *Planned Parenthood League of Massachusetts v. Bellotti*, 641 F.2d 1006 (1st Cir. 1981); *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980); *Planned Parenthood Ass'n of Kansas City, Missouri, Inc. v. Ashcroft*, 655 F.2d 848 (8th Cir. 1981); *Women's Services, P.C. v. Thone*, 636 F.2d 206, (8th Cir. 1980) *vacated and remanded*, 452 U.S. 911 (1981); *Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979); *Friendship Medical Center v. Chicago Bd. of Health*, 505 F.2d 1141 (7th Cir. 1974); *Margaret S. v. Edwards*, 488 F. Supp. 181 (E.D. La. 1980); *Planned Parenthood of Rhode Island v. Roberts*, 530 F. Supp. 1136 (D.R.I. 1982); *Leigh v. Olson*, 497 F. Supp. 1340 (D.N.D. 1980); *Women's Community Health Center, Inc. v. Cohen*, 477 F. Supp. 542 (D. Me. 1979); *Munson v. Meierhenry*, No. 80-3043 (D.S.D. Feb. 27, 1981); *Wolfe v. Stumbo*, No. C-80-0285-L(A) (W.D. Ken. Dec. 3, 1980); *Orr v. Knowles*, CV 81-0-301, CV 81-167 (D. Neb. May 30, 1981); *Eubanks v. Brown*, C-82-0360 L(A) (E.D.Ky. July 9, 1982) (two hours); *Glick v. List*, Civ. No. R-81-150-BRT (D. Nev. July 7, 1981); *Aware Woman Clinic, Inc. v. City of Cocoa Beach*, C.No. 77-361-Drl-Civ-4, (M.D. Fla., April 21, 1978); *Planned Parenthood of Memphis v. Alexander*, No. 78-2310 (W.D. Tenn. March 23, 1981) *appeal dis'd mem.*, 665 F.2d 1046 (6th Cir. 1980); *Mobile Women's Medical Clinic v. Bd. of Comm'rs*, 426 F. Supp. 331 (S.D. Ala. 1977).

65 These risks are significantly greater in the many states in which there are few abortion providers. For example, in North Dakota, where there is only one abortion provider, the additional expenses required by two trips or a two-night stay would have a "significant and substantial burden on a large number of women, especially on women in areas of western North Dakota who would have to travel over 400 miles to obtain an abortion." *Leigh v. Olson*, 497 F. Supp. 1340, 1347 (1980).

66 The woman's privacy interest in maintaining her anonymity is also jeopardized. Like the person who obtains contraceptives by mail to maximize confidentiality, the woman seeking an abortion has a strong interest in

of § 1870.07 is to require a "cooling off period during which second thoughts might come into play." (Pet.A.17a.) These "second thoughts" are not thoughts based on objective medical information, but rather "second thoughts" generated by the frightening misinformation dictated by § 1870.06(B). (D.Brief, p. 47.) The mandatory wait is intended to reinforce the value of the prescribed information, and also suggests to the woman that her decision to seek an abortion is not to be trusted. Rather than promoting any state interest, the waiting period is designed to interfere with the woman's right of privacy.

C. The Post-First Trimester Hospital Requirement of Section 1870.03 Unnecessarily Burdens Women and Does Not Further Any Legitimate Maternal Health Interests.

Section 1870.03 requires that every abortion after the first 12 weeks of pregnancy be performed in a hospital.[67] Plaintiffs demonstrated at the time of trial that there were no hospitals in Akron in which such abortions could be performed, and established the safety and widespread use of the D&E abortion technique for second trimester abortions in clinics. (See Facts, pp. 9-12, *supra.*) The court of appeals, while indicating that it found other cases striking down identical second trimester hospital restrictions "persuasive" (Pet.A.21a.), upheld § 1870.03 on the basis of this Court's summary affirmance in *Gary-Northwest Indiana Women's Services, Inc. v. Bowen,* 496 F. Supp. 894, (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Services, Inc. v. Orr,* 451 U.S. 934 (1981).[68]

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keeping it private. *Carey v. Population Services International,* 431 U.S. at 691 (Powell, J., concurring.) Since a waiting period necessitates two trips, instead of one, a woman will miss an extra day of work or school, increasing the risk that her abortion will become known.

[67] Section 1870.03 replaced an earlier identical restriction that had been in effect since 1975. (Pet.A. 54a.) However, one clinic provider testified that they wanted to provide early second trimester D&E abortions, and would do so if there were no legal barriers. (Goldberger, T.II, 128.)

[68] As indicated in Petition for Certiorari, this case differs significantly from *Gary-Northwest* in at least three ways: First, the Indiana statute defines

In *Roe v. Wade,* 410 U.S. 113 (1973), this Court found that the state's interest in protecting maternal health becomes "compelling" at the end of the first trimester because, at that point, "mortality with abortion is equal to childbirth." *Id.* at 163. At that point in pregnancy, "a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health." *Id.* at 163.

In *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 79, this Court examined a Missouri statute outlawing the use of saline amniocentesis after the first trimester of pregnancy and held that it was "unreasonable," "arbitrary," and "designed to inhibit, and [had] the effect of inhibiting, the vast majority of abortions after 12 weeks."[69] The Missouri statute was unconstitutional because, at the time of trial, saline amniocentesis was widely accepted in the medical community, abortions by other methods were not available in Missouri, and the prohibition increased risks to the women it was supposed to protect. *Id.* at 77-78.

Section 1870.03 has precisely the same effects. Today, second trimester D&E abortions performed in outpatient facilities are prevalent and widely accepted in the medical community. (Facts, pp. 9-12, *supra.*) Furthermore, because hospital facilities for second trimester abortions are not available in Akron, the prohibition of § 1870.03 increases costs and health risks for women who must either travel or forego an abortion. This

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"hospital" to include ambulatory outpatient centers; second, there was no full trial in Gary-Northwest—the questions presented in the jurisdictional statement were procedural, not substantive; and third, the district court in *Gary-Northwest* found several evidentiary failures not present in this case. (496 F. Supp. at 903.) Because of these differences, *Gary-Northwest* is not binding precedent. See *Tully v. Griffin, Inc.,* 429 U.S. 68, 74-75 (1976); *Edelman v. Jordan,* 415 U.S. 651, 671 (1974).

[69] This Court has recognized that state regulations which limit access to the means of effectuating the exercise of privacy decisions are subject to the same scrutiny as are laws which would prohibit the decision entirely. *Carey v. Population Services International,* 431 U.S. at 688.

prohibition not only fails to promote maternal health, but also significantly increases risks to maternal health and life.[70]

Defendants completely failed to meet their burden of showing that § 1870.03 is narrowly tailored to promote maternal health. When § 1870.03 was passed by the City Council, hospitals in Akron were unavailable to do second trimester abortions.[71] It was incumbent on defendants to show that second trimester hospital abortions were available at the time of trial, and they failed to do so. *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. at 78 n.12, 92 (Stewart, J. and Powell, J., concurring), 102 (Stevens, J., concurring). The sole evidence offered by defendants to justify § 1870.03 was that the American College of Obstetricians and Gynecologists (ACOG) had not changed its 1973 recommendation that second trimester abortions be performed only in hospitals. (Pet.A.19a.) Subsequent to the trial, the ACOG changed its standard and now recognizes the safety of out-patient second trimester abortion services. (Appendix B to this

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70 In *Planned Parenthood Ass'n of Kansas City v. Ashcroft,* 664 F.2d 687 (8th Cir. 1981), the court struck down a Missouri statute identical to § 1870.03, finding out-of-hospital second trimester D&E abortions no more dangerous to maternal health than hospital procedures. *Id.* at 690. In *Margaret S. v. Edwards,* 488 F. Supp. 181 (E.D. La. 1980) the court struck down the second trimester regulation because no hospitals in Louisiana were available for any abortions, and because the law would "effectively halt the performance of post-first trimester abortions in Louisiana." The court found that "[t]his result endangers maternal health by forcing a woman . . . to select from a range of alternatives more dangerous to maternal health than performance of a post-first trimester abortion in a clinic where such abortions are now safely performed." *Id.* at 192, 193.

71 The Sixth Circuit found that there were only two hospitals in Akron in which second trimester abortions were performed, and that in the year before trial only nine such abortions had been performed. (Pet.A. 19a.) Out of these nine, one hospital listed two out of three as "therapeutic" (P.Ex. 47, J.A. 302a.); of the six performed at the other hospital, five were for the removal of dead fetuses. (P.Ex. 46, J.A. 300a; Ohio Admin. Code § 3701-47-01(E), P.Ex. 45, T. 22.) During that same period of time, approximately 600 women needing second trimester abortions had to be referred to Cleveland or Michigan. (Pet.A. 19a.) There was unrebutted testimony that, at the time of trial in 1978, no second trimester abortions were available in any Akron hospital. (Gotshall, J.A. 112a-113a.)

Brief.) Therefore, defendants have presented absolutely no evidence that an in-hospital requirement for all second trimester abortions promotes health interests; in fact, it burdens all women needing such abortions and effectively vetoes the choice of some.

D. The Fetal Disposal Requirement of Section 1870.16 is Unconstitutionally Vague.

Both the district court and the court of appeals found § 1870.16, which requires that fetal remains be disposed of in a "humane" manner, to be unconstitutionally vague. Like the statute stricken in *Colautti v. Franklin,* 439 U.S. 379 (1979), § 1870.16 forces physicians to speculate on the meanings of ambiguous language at the risk of criminal prosecution. "Humane" is a word which, as the district court found, "can evoke a totally different understanding in each individual listener." (Pet.A.103a.) "It therefore presents serious problems of notice, discriminatory application, and chilling effect on the exercise of constitutional rights." *Colautti v. Franklin,* 439 U.S. at 394.

Use of the word "humane" to describe the disposal of fetal tissue suggests that such tissue should be treated as though it were a deceased human being. This requirement is unrelated to any legitimate state interest.[72]

Defendants have never proffered a meaning for "humane," either to this Court or to the court of appeals. (D.Brief, pp. 48-49.) Instead, they rely on *Planned Parenthood Association v. Fitzpatrick,* 401 F. Supp. 554 (E.D.Pa. 1975) *aff'd mem. on*

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72 A doctor who removes a fetus which has already died inside the uterus, a procedure which is exempted from the definition of "abortion" in § 1870.01(A), has no obligation to handle the tissue "humanely." Similarly, disposal of the fetal products of a spontaneous abortion are unregulated by the Akron ordinance. The state law, cited by defendants (D.Brief, p. 48.), which requires "humane" disposal of the "fetus," Ohio Admin. Code § 3701-47.05, contains no language limiting its scope to induced abortions. It is limited, however, by the definition of "fetus" in § 3701-47-01(E), to products of conception removed after the fourteenth week of pregnancy. Section 1870.16 thus functions solely to impose a penalty on doctors who perform abortions.

other grounds sub nom. Franklin v. Fitzpatrick, 428 U.S. 901 (1976),[73] in which the district court upheld a Pennsylvania law requiring promulgation of regulations for the "humane" disposal of fetal tissue. The provision at issue was not a criminal law but "merely an enabling statute" 401 F. Supp. at 573. Standards for vagueness are less stringently applied to laws such as enabling statutes than to criminal statutes. *Winters v. New York,* 333 U.S. 507, 515 (1948).

The district court, in *Fitzpatrick,* found that the Pennsylvania disposal law was grounded in the state's interest in protecting public health.[74] The Akron ordinance, by contrast, mandates disposal in a "humane *and* sanitary" manner, thus requiring physicians to use methods which are more than sanitary in order to escape a criminal penalty.[75] The Sixth Circuit correctly found that "[t]he possibility that the language of § 1870.16 might be construed to mandate some sort of 'decent burial' of an embryo at the earliest stages of formation is too real to be overlooked." (Pet.A. p. 24a.)

The defendants attempt to redeem § 1870.16 by arguing that the word "humane" should be excised. The severability clause in § 1870.19 does not suggest that words within a sentence can be severed. Nor is there any reason to believe that the City Council would have enacted § 1870.16 without including the

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[73] The only question presented on appeal to this Court was the constitutionality of the "informed consent" provisions of the statute. 44 U.S.L.W. 3375 (Dec. 23, 1975). Thus the summary affirmance did not include the lower court's ruling as to fetal disposal.

[74] The defendants attempt to import the legislative intent behind the Pennsylvania law to Akron, by citing Pennsylvania's asserted desire "to preclude the mindless dumping of aborted fetuses on to garbage piles," *Planned Parenthood Ass'n v. Fitzpatrick,* 401 F. Supp. at 573, as establishing the intent of the Akron City Council. (D.Brief, at 48.) That phrase, however, appears in *Fitzpatrick* as one of the examples given by the state of "obvious public health considerations regarding sanitation [and] disease prevention." *Id.* at 573. Akron's interest in public health is served by the specific "sanitary" disposal language in § 1870.16.

[75] Canons of construction require that a statute be interpreted so as not to render phrases redundant or superfluous. *Colautti v. Franklin,* 439 U.S. at 392.

word "humane". *Champlin Refining Co. v. Corp. Commission of Oklahoma,* 286 U.S. 210, 234 (1932). Fetal tissue is referred to in § 1870.16 as "the unborn child," a phrase which is repeated throughout the ordinance. The concepts of "humane" disposal and "unborn child" are entangled in the legislative intent, making it impossible to repair the unconstitutionality of this section by judicial editing.

III.

SECTION 1870.05(B) IS NOT PROPERLY BEFORE THIS COURT BECAUSE NO PARTY WITH ARTICLE III STANDING APPEALED TO THE COURT OF APPEALS.

The district court held that § 1870.05(B), requiring parental consent for a minor's abortion, was unconstitutional. (Pet.A. 92a.) Defendant City of Akron did not appeal that ruling to the court of appeals. (Pet.A. 11a.) The City is hence foreclosed from obtaining review of that question in this Court (*United States v. Santana,* 427 U.S. 38, 41 n.2 (1976); *Adickes v. S.H. Kress & Co.,* 398 U.S. 144, 146 n.2 (1970); *California v. Taylor,* 353 U.S. 553, 556 n.2 (1957)), despite the fact that the issue was raised in the Sixth Circuit by the defendant-intervenors. *O'Bannon v. Town Court Nursing Center,* 447 U.S. 773, 783 n.14 (1980).

In *O'Bannon,* this Court was faced with the same question: whether a defendant who acquiesces in an adverse ruling at the district court level, which its co-defendant appeals to the court of appeals, can then raise the issue in the Supreme Court. This Court held that the defendant's waiver of that issue in the court of appeals precluded Supreme Court review, even though its co-defendant, who did not petition for certiorari, raised the question below. *Id.* at 783 n.14.

As in *O'Bannon,* the Court should not allow the City of Akron to invoke the defendant-intervenor's appeal to cure its waiver on the parental consent issue, particularly since the

intervenors had no Article III standing necessary to prosecute an independent appeal in the Sixth Circuit.[76]

The district court, pursuant to Fed.R.Civ.P. 24(b)(2), permitted the intervenors to participate as defendants "solely in their individual capacity as parents of unmarried minor daughters of childbearing age." (Pet.A. 45a.) While a party seeking to intervene in the district court need not possess the standing necessary to initiate the lawsuit, *Trbovich v. United Mine Workers of America,* 404 U.S. 528 (1972), an intervenor "does not automatically have the ability to appeal a decision which all other parties have decided not to appeal." *United States v. Imperial Irrigation District,* 559 F.2d 509, 521 (9th Cir. 1977), *rev'd on other grounds sub nom. Bryant v. Yellen,* 447 U.S. 352 (1980). Here, because the City "acquiesced in the judgment against them, [the intervenors had to] demonstrate such a stake in the outcome of an appeal that a live Article III case or controversy remains for appellate resolution." *Legal Aid Society of Alameda County v. Brennan,* 608 F.2d 1319, 1328 n.9 (9th Cir. 1979), *cert. denied,* 447 U.S. 921 (1980). The intervenors did not attempt to demonstrate their standing in their own right; any effort to do so would have failed resoundingly.

None of the intervenors' daughters were then pregnant. *See Roe v. Wade,* 410 U.S. at 127-129. The intervenors did not allege that their daughters were sexually active, likely to become pregnant, or that if their daughters were to become pregnant, they would seek an abortion in Akron. The speculative chain of events which must be envisioned here can hardly satisfy the minimum Article III requirement that the litigant show "an injury to himself that is likely to be redressed by a favorable decision." *Simon v. Eastern Kentucky Welfare Rights Organization,* 426 U.S. 26, 38 (1976).[77] Furthermore, at

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[76] Although plaintiffs did not question the standing of the intervenors in the Sixth Circuit, it is well-settled that the question of standing cannot be waived, and Article III limits judicial power to justiciable controversies. *Doremus v. Bd. of Educ. of the Borough of Hawthorne,* 342 U.S. 429 (1952).

[77] In *Fisher v. Tucson School Dist. No. One,* 625 F.2d 834, 837 (9th Cir. 1980), and *Barry v. Dist. of Columbia Board of Elections and Ethics,* 580 F.2d 695 (D.C. Cir. 1978), the courts refused to hear appeals brought by intervenor-appellants who lacked Article III standing.

the time of trial in 1978, the two intervenors each had 14 year old daughters (Black, T.VI, 153; Seguin, T.VII, 49). While they testified that they had younger children, they did not specify their age or sex. Since the two minors were over age 15 when this case was before the circuit court, their claims were moot. *Craig v. Boren*, 429 U.S. 190, 192 (1976). Because defendants did not appeal to the circuit court, and the intervenors lacked standing, this Court should dismiss defendants' Petition for Certiorari on § 1870.05(B) as improvidently granted.

IV.

THE PARENTAL CONSENT REQUIREMENT IS UNCONSTITUTIONAL BECAUSE IT PROVIDES NO JUDICIAL ALTERNATIVE FOR MATURE OR BEST INTERESTS MINORS.

If this Court reaches the merits of § 1870.05(B), it must affirm the ruling that this section is unconstitutional:

> [A] State may not validly require notice to parents in all cases, without providing an independent decisionmaker to whom a pregnant minor can have recourse if she believes that she is mature enough to make the abortion decision independently or that notification otherwise would not be in her best interests.

H.L. v. Matheson, 450 U.S. 398, 420 (1981) (Powell, J., concurring); *see also Bellotti v. Baird*, 443 U.S. 622, 642-48 (1979).

Section 1870.05(B) prohibits physicians[78] from providing abortions to girls under age 15 unless the physician first

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[78] The district court found that plaintiff physician Bliss had standing to raise the claims of his minor patients under age 15. (Pet.A. 56a.) *Accord; Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Bellotti v. Baird*, 443 U.S. at 627 n.5 (1979) (upholding the standing of plaintiff physician to raise constitutional claims of the statute "as applied to all pregnant minors who might be affected by it. We accept that the rights of this entire category of minors [immature and mature] properly were subject to adjudication."). In the present case, where the lower courts denied all requests to proceed pseudonymously (R.15, R.26, R.31, R.32; Pet.A.

obtains the written consent of a parent or an order from a court "that the abortion should be performed." The district court struck down this statute because both the parents and the court could arbitrarily veto a minor's abortion. (Pet.A. 92a, *aff'd.*, Pet.A. 12a.)[79]

Although § 1870.05(B) states that "a court having jurisdiction over her" might order "that the abortion be performed," it does not specify which court, the procedures to be followed, or the ground upon which such an order might be based.[80]

Defendants suggest that the juvenile court of Ohio is the "court having jurisdiction over [the minor]." (D.Brief p. 4, 26.) However, the juvenile court is a forum of strictly limited jurisdiction. The only circumstance in which the juvenile court can authorize non-emergency medical treatment is upon a finding of parental neglect.[81] Ohio Rev. Code Ann. § 2151.03 (J.A. 325a) defines a neglected child as one

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22a), the physician is not only the "best available proponent," *Singleton v. Wulff*, 428 U.S. 106, 116 (1976), but considering all the circumstances, an immature, "best interests" pregnant plaintiff is "in all practical terms impossible." *Id.*, 428 U.S. at 126 (Powell, J., dissenting). The plaintiff clinics, who may be held both civilly and criminally liable for failing to comply with the ordinance, also have standing to raise the claims of their patients. *Flast v. Cohen*, 392 U.S. 83, 101 (1968); *Eisenstadt v. Baird*, 405 U.S. 438, 443-445 (1972); *Carey v. Population Services International*, 431 U.S. 678, 682-684 (1977).

79 In striking down § 1870.05(A), a parental notice provision not before this Court, that contains the same court bypass as § 1870.05(B), the district court held there was no judicial alternative because state juvenile court rules require parents be notified in every case. (Pet.A. 93a.) *See also, In re Corey*, 145 Ohio St. 413, 61 N.E.2d, 892 (1945).

80 Defendants erroneously assert (D.Brief, p. 26) that plaintiffs did not raise the inadequacy of the court alternative. The issue was argued to the trial court (R.196, p. 7-9), which held that the judicial alternative for parental notice was unconstitutional because of mandatory notice in the juvenile court procedure. (Pet.A. 93a.) Furthermore, subsequent to this Court's decision in *Bellotti v. Baird*, 443 U.S. 622 (1979), plaintiffs filed two post-trial supplementary briefs on this issue. (R. 247, filed July 25, 1979; R. 249, filed August 15, 1979.)

81 Ohio Rev. Code Ann. § 2151.23 (J.A. 326a) defines the jurisdiction of the juvenile court to hear petitions: "(A) (1) concerning any child who on

> [w]hose parents, guardian or custodian neglects or refuses to provide him with proper or necessary subsistence, education, medical or surgical care, or other care necessary for his health, morals, or well being.

Perhaps to get around the problem of the limited jurisdiction of the juvenile court, defendants assert that the court is available only where "the parents or guardian are either unavailable or refuse consent." (D.Brief, p. 4.) This interpretation is contrary to the plain language of Section 1870.05(B), which provides for a court bypass as an alternative to parental consent, not as a means of appealing a parent's refusal. Defendants do not say what happens to those minors whose best interests require that one or both parents not be informed, nor to those minors who are mature; for these two groups there is no court alternative.

Defendants assert that this statute is directed only "at minors unable to give an effective consent" (D.Brief, p. 25.),[82] ignoring the extensive evidence by both plaintiffs' and defendants' witnesses, as well as the district court findings (Pet.A. 93a), that there are Akron minors under 15 who are mature enough to make a well informed decision, and that there are some whose best interests require that their parents not be involved. (See *Facts*, pp. 13-14, *infra*.)

There are other constitutional infirmities inherent in the juvenile court as well:[83] juvenile courts have no power to render

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or about the date specified in the complaint is alleged to be a juvenile traffic offender, delinquent, unruly, abused, *neglected*, or dependent." (Emphasis added) Both parents are automatically notified when a juvenile court proceeding is begun. Ohio Rev. Code Ann. § 2151.28 (Pet.A. 93a). If a doctor is not willing to certify an emergency as defined by § 1870.12, the minor who has serious health problems may seek an order for emergency medical care from the juvenile court; however, even under this procedure, notice to the parents is mandated. Ohio Rev. Code Ann. § 2151.33 (J.A. 328a-329a).

82 A state may not, in the abortion context, enact a statute that precludes "the opportunity for case by case evaluations of the maturity of pregnant minors." *Bellotti v. Baird*, 443 U.S. 622, 643 n.23 (1979).

83 For authority in asserting additional grounds in support of the judgment striking down § 1870.05(B), *see Toll v. Moreno*, 50 U.S.L.W. 4880 n.26 (U.S. June 28, 1982); *Dandridge v. Williams*, 397 U.S. 471, 475 n.6 (1970).

an adjudgment of maturity; the court may apply only a "best interest" standard with the parents charged with neglect;[84] the Ohio juvenile court provisions do not assure expeditious consideration of minors' petitions for abortions, nor that they be confidential.

The evidence in the record shows that nearly all minors under age 15 are accompanied by at least one parent, and the few who are not are the victims of tragic or desperate family situations. There are parents who will never consent to an abortion regardless of health or life concerns and will "obstruct both an abortion and . . . access to court." *Bellotti v. Baird*, 443 U.S. at 647.

For this reason, this Court has consistently held that if a state seeks to encourage parental involvement in the abortion decision, it must provide some effective means by which minors who are mature, or whose best interests would be threatened by parental involvement, may obtain an abortion without parental notification or consent.

CONCLUSION

This Court should dismiss as improvidently granted defendants' petition for a writ of certiorari on Section 1870.05(B) or, in the alternative, affirm the judgment of the court of appeals on Section 1870.05(B); affirm the judgment of the court of appeals on Sections 1870.06(B) and (C), 1870.07, and 1870.16; and vacate the judgment of the court of appeals on Section 1870.03, and remand the issue to the court of appeals for further proceedings.

Dated: New York, N.Y.
August 27, 1982

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[84] Although Judge Kennedy in the Sixth Circuit Court of Appeals states that § 1870.05(B) may be constitutional if "the order from a court having jurisdiction was based, as it constitutionally must be," (Pet.A. 33a) on a maturity inquiry, it is clear that Ohio juvenile court has no jurisdiction to make this type of judgment. Further, defendants admit that the City of Akron could not modify the state juvenile court statute since to do so would be unconstitutional under the Ohio constitution. (D.Brief, p. 27.)

Respectfully submitted,

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